Being Least Intrusive

An orientation to practice in responding to situations of abuse, neglect and self-neglect of vulnerable First Nation adults

April Struthers B.A., M.Ed., R.C.C.

Lindsay Neufeld MSW RSW

June 2010

Working Paper, 2nd Edition

Working paper

'When you walk on a journey with someone, you don't get far if you are pushing them off the road.'

"Our Elders have for so many years had people push into their lives. We as health professionals think we have authority to do that. We need to remember it is a privilege and honor to be involved in Elders lives-we need to give honor and dignity."

"You can be accepted by Elders so you can do your job – make yourself present and you will know when they accept you."

Dorothy Hutchinson, RN,
Home and Community Care Director,
Peter Valentine Reserve
Grand Rapids , Manitoba

Working Paper

Table of Contents

Executive Summary ... 4
Introduction ... 6
Foundational Principles: ... 7
Most Effective, Least Intrusive: BC Adult Guardianship Legislation ... 7
Critical awareness and reflexivity: Anti-oppressive SW Theory & Practice ... 8
Vulnerability Re-Conceptualized: The Vanguard Project ... 9
Cultural history & Indigenous ways of knowing: Aboriginal Social Work Theory & Practice ... 10
Cultural Safety: a different way to measure outcome ... 11
Specific Models of Cross Cultural Practice ... 12
First Nations Holistic Policy and Planning Model: social determinants of health approach ... 12
First Nations RHS Cultural Framework ... 13
Listening for Meaning: an Integrative Model ... 16
Conclusion ... 19
Being Least Intrusive: mitigating risk and vulnerability in the area of abuse and neglect ... 19
Authors: ... 22
Bibliography ... 23
Appendix 1: ... 26
Flowchart of process: being least intrusive in response and intervention ... 26

working paper

Executive Summary

“Being least Intrusive” is an orientation to front line practice in responding to situations of abuse and neglect of vulnerable First Nation adults. It has emerged from the challenges and complexity of inter-professional and cross-cultural practice in addressing issues of vulnerability and safety, balancing values of autonomy and self-determination with the desire and in some cases the legislated responsibility to intervene and protect, and offering support and assistance in ways that are experienced by the adult as culturally safe, meaningful and effective. It is a hybrid approach to practice drawing on indigenous knowledge, values and worldview, key concepts from critical social work theory and models of cross cultural practice and first-hand accounts of response and prevention initiatives within First Nation communities across Canada.

Operationally, mainstream health care service and delivery is grounded in and organized around a biomedical understanding of health, which primarily defines health in relation to the functioning of an individual’s physical body and mind and the presence or absence of an illness or disease. There is perhaps no other area in front line health care practice that exposes the shortcomings of a medically driven approach to care than in the complex work of responding to situations of abuse and neglect of vulnerable adults. Intervening effectively to mitigate risk and vulnerability requires an understanding of the social, historical and cultural context in which the adult lives, attention to the interplay between the adult and his or her family, caregivers, and community, and assessment of the physical, mental, emotional and spiritual functioning of the adult. Increasing the complexity of this work further, is a clear recognition that a different orientation to practice is needed when responding to situations of abuse and neglect of vulnerable First Nation adults, families and communities.

“Being least intrusive”, as an orientation to practice, presents a fundamentally different approach to health care delivery; while outcome continues to be important, it is the quality of process that ensures the realization of the best outcomes. When responding to situations of abuse and neglect of vulnerable First Nation adults, we believe that ‘being least intrusive’ means that the outcome of our encounters as health care providers with the First Nation adults with whom we work, regardless of the level of our involvement or intervention, be ‘culturally safe’. As Jessica Ball (2006) outlines, cultural safety as an outcome is contingent upon respectful relationships, equitable partnerships and the quality of engagement.

More than a list of steps to follow “Being Least Intrusive” as an orientation to practice, challenges frontline clinicians to approach their work in responding to situations of abuse and neglect of vulnerable First Nation adults differently. It

Working Paper

requires a critical understanding of vulnerability, abuse and neglect in the historical, social and cultural context within which it emerges and is experienced. It requires reflexivity and a critical self-awareness of social location and power in relationship to the individuals, families and communities with whom we work. It challenges clinicians to be thoughtful, intentional and respectful in the way we engage. In this way, we believe being least intrusive means being collaborative, recognizing and acknowledging the strengths, resiliency, capacity of individuals, families and communities and co-crafting effective and meaningful support and assistance plans that ensure safety, protect dignity and ultimately encourage empowerment and agency.

We acknowledge that this approach is directed mainly at non-aboriginal clinicians and service providers who work with aboriginal individuals, families and communities in responding to situations of vulnerability, abuse and neglect. It would not have been possible without the direct learning that has come from frontline work and the wisdom and knowledge that has been shared by our First Nation colleagues, community leaders and engaged individuals through dialogue and example, in practice and in partnership. It is our hope that this approach will contribute to more effective and more meaningful health care delivery; that it will be a springboard for collaboration and partnership across cultures and that it will be utilized as a tool to build individual and collective capacity to be aware of, respond to and ultimately prevent situations of abuse and neglect of vulnerable adults.

Working Paper

Introduction

A fundamental struggle that faces front line clinicians working in the area of abuse and neglect of vulnerable adults, in particular First Nations elders, is ***how*** to be "*least intrusive and most effective*" knowing that the very presence of mainstream health care clinicians, historically, has been experienced by indigenous people as 'intrusive'. From this struggle and from collaborative dialogues with First Nation communities around the issues of vulnerability, abuse & neglect, emerged a desire to articulate an orientation to practice that is culturally relevant and safe; an approach to practice that honors cultural and spiritual diversity and creates space for deeper understanding, healing and restorative action.

This orientation to practice is a "hybrid" approach, drawing on indigenous knowledge, valuable concepts and models of cross cultural practice and social work theory, insight from research on abuse prevention and social determinants of health, and anecdotal accounts of community abuse prevention and response projects from First Nations communities across Canada. From our dialogues and work with First Nation individuals, families and communities it is clear that there has been proactive engagement in various processes of restoration and healing, each unique to the cultural and practical needs of specific communities.

Understanding our position as health care workers in addressing the complex issues of vulnerability, abuse and neglect, we recognize that the potential for re-victimization is great, given the individual and collective intergenerational impact of colonization, residential school and other forms of systemic oppression experienced by First Nation people. We acknowledge that the standardized assessment tools and practices utilized by the health care system and mainstream service providers are likely not fully adequate. Even more, they may not be not be culturally relevant, meaningful or helpful in bringing clarity to complex situations or effective in identifying care needs enough to develop appropriate support and assistance plans for vulnerable individuals and their families. It is this complex terrain that we endeavor to traverse effectively and responsibly – creating safety for individuals, families and communities, opening space for collaboration and partnership, and contributing to experiences of restoration and healing.

It is important to note that this orientation to practice has been developed by front line social workers working in Vancouver Island Health Authority's (VIHA) Home and Community Care (HCC) Program in partnership with a community development, organizational and prevention consultant. It has emerged from the challenges of practice in the area of abuse and neglect of vulnerable adults and ongoing dialogue with our First Nation colleagues, clients and community leaders. Although this paper references the specific practice environment of

Working Paper

British Columbia, which has provincial legislation that provides for the support, assistance and protection of vulnerable adults we believe that this orientation to practice itself represents a paradigm shift applicable across legislative jurisdiction and geographic region.

Foundational Principles:

Most Effective, Least Intrusive: BC Adult Guardianship Legislation

In British Columbia, the Adult Guardianship Act (part 3), proclaimed into law in 2000, provides for the support, assistance and protection of adults who are abused, neglected and/or self-neglected and who are unable to seek support and assistance independently. There are several important principles that guide the administration and interpretation of the act itself and the actions of 'designated responders' in their role in investigating reports of abuse and neglect and developing support and assistance plans for vulnerable adults. One of the principles is that "all adults should receive the '*most effective, but least restrictive and intrusive'* form of support, assistance and protection when they are unable to care for themselves and/or their assets". In principle, it seems fairly straight forward; in practice it is a challenging and complex endeavor.

In our western culture we hold steadfast to values of autonomy and self-determination. We believe that adults have the right to live independently, to choose for themselves how they want to live – even if that means living at risk. So when one's autonomy and self-determination is threatened or undermined by illness, injury, disease, disability, poverty and other crippling life circumstances one becomes more vulnerable, the consequence of which include dependency on others for definition and direction. Regardless of whether the process is sudden or happens over the course of a lifetime, the experience of becoming dependent on others is often disempowering and restrictive. In the context of health care, in particular, what is seen as dependency and vulnerability is often justification for non-consensual and paternalistic intervention (BCANPC, 2008, p.15). It is no surprise then that our presence and actions as health care clinicians, 'designated responders', and/or 'outsiders' into the lives of vulnerable adults, however well intentioned and necessary, is often experienced as intrusive.

While this legislation is specific to BC, the guiding principles and objectives are applicable across jurisdictions. The challenge this legislation presents to frontline clinicians and service providers is 'how to be most effective while being least intrusive'. In the context of non-aboriginal mainstream health care clinicians responding to situations of abuse and neglect of vulnerable First Nation adults,

Working Paper

understanding what it means to 'be least intrusive' is an even more complex endeavor.

Critical awareness and reflexivity: Anti-oppressive SW Theory & Practice

Anti-oppressive practice can best be understood in general as a critical orientation to social work practice. A central element to this practice orientation is an understanding of oppression and the dynamics that (re) produce it, and the deleterious effect that social divisions and structural inequalities have on a person's sense of self and his or her experience in the world. Through this understanding emerges a creative and collaborative process of change whereby individuals and communities are empowered to resist and redress inequality, oppression and marginalization through consciousness-raising, linking personal experience with material, social and political conditions, and challenging the imbedded bias and discrimination that serves to sustain relationships of domination and power.

Central to working with vulnerable adults from an anti-oppressive stance is the primary recognition that the power differential between clinician and client is staggering. In health care there is a 'taken-for-granted' assumption that scientific expertise qualifies clinicians to intervene in the lives of clients whilst their own experiences and wishes count for little. One of the many challenges for the clinician, therefore, is to be cognizant of the dynamics of oppression embedded in unspoken assumptions and structural dynamics that serve to perpetuate disadvantage and inequality and in response develop empowering forms of practice whereby individual clients and communities can exercise individual and collective agency to effect lasting change.

Another crucial feature of anti-oppressive practice is linking people's life stories to the broader social and historical context from which they emerge – connecting the 'personal' with the 'political'. Vulnerability, abuse and neglect need to be understood not simply as individual problems resulting from physical and cognitive decline, but rather understood within a specific historical, social, cultural, political and economic context. By doing so, the clinician moves away from focusing on the pathology of the individual, to honoring the interconnection and interactions between the client's story and the social systems he or she encounters. From this stance, the nature of the assessment changes and so to does the solution. It opens up possibilities for empowerment and transformation, through creative, collaborative, meaningful and effective interventions.

Working Paper

Vulnerability Re-Conceptualized: The Vanguard Project

Whether there is adult protection legislation or not, vulnerability is a concept closely linked to the discussion and debate regarding adult protection and elder abuse and neglect in jurisdictions across Canada. One of the greatest concerns has been its inextricable link to incapability, as if the two are static conditions contingent on each other. Of most concern is that the label of 'vulnerable' or 'incapable' as a result of circumstances of abuse and neglect becomes justification for nonconsensual and paternalistic intervention, which impinges on the adult's right to autonomy and self-determination.

One of the objectives of the Vanguard Project, an initiative of the BC Adult Abuse/Neglect Prevention Collaborative, is to create a shared, inter-disciplinary understanding of the meanings and implications of such concepts as vulnerability and capability, in such a way as to promote broader and more effective support and protection measures as well as highlight the potential and possibility for prevention. Central to this objective is re-conceptualizing the concept of vulnerability. The Vanguard Project argues that vulnerability needs to be understood as a complex notion that extends beyond a fixed descriptor of the adult being abused and neglected. They adopt a new understanding of vulnerability as outlined below:

- **Vulnerability is relative and dynamic**– A person is more or less vulnerable. It is not an absolute state rather one that can change as social conditions change.
- **Vulnerability is relational.** A person is always vulnerable in relation to something else.
- **Vulnerability is not reducible to a disability issue.** A disability or a medical condition may or may not give rise to vulnerability depending on the circumstances. Conversely, other social conditions may render a person vulnerable whether or not the person has a disability or medical condition.
- **Vulnerability is a social condition.** Because of stigma and structural inequality social factors such as poverty, isolation, lack of education, homelessness, age, culture and language barriers, history of abuse, mental illness, addiction, gender or sex, and sexual orientation are all indicators of vulnerability.
- **Vulnerability is not an inherent quality.** It is not a character flaw or personal failing. It arises out of the interaction between an individual and his or her social environment (including the potential abuser, family system, socio-economic conditions, historical and cultural context).

Working Paper

From *Vulnerable Adults and Capability Issues in BC: Provincial strategy Document*. January 2009. BC Adult Abuse / Neglect Prevention Collaborative.(p.16)

Understanding vulnerability as a social condition is helpful in broadening the scope of our assessment and expanding the potential avenues for intervention on both an individual and community level. Adopting this understanding of vulnerability is crucial in working with First Nation individuals and communities. It is clear that many of the social factors that have and continue to exist in First Nation communities - poverty, lack of adequate housing, isolation, addiction and barriers to accessing education and health services, among others – give rise to individual and collective vulnerability. The experience and intergenerational impact of colonization and ongoing systemic marginalization and oppression make efforts to mitigate risk, respond to vulnerability and offer culturally safe and effective support and assistance challenging and complex.

Cultural history & Indigenous ways of knowing: Aboriginal Social Work Theory & Practice

Aboriginal social work is relatively new, emerging out of the aboriginal social movement of the 1970s and evolving in response to the recognition and need for social work to be culturally relevant to Aboriginal people. Central to this approach to practice is its incorporation of a critical awareness of aboriginal history within the specific context of colonialism and its grounding in an aboriginal worldview perspective, which is comprehensive and spiritual in nature (Sinclair, 2004). The foundation for service delivery and practice is shaped by the uniqueness of Indigenous ways of knowing, values and traditions, a holistic understanding of health and social well-being as well as the need to address the historical and contemporary impact of colonization. There are several key concepts that underpin Aboriginal worldview two of which are: the concept of "all my relations" and the concept of the "sacred". Both serve as a reminder of the intrinsic interconnection of all that is in existence and a reverence for the intrinsic wholeness, sacredness and value of self and others (Butot, 2009; Sinclair, 2004).

The interrelatedness and interconnectedness central to aboriginal epistemology is often taught and understood visually and symbolically through the medicine wheel. While it is not utilized universally by all First Nations, the medicine wheel provides a useful 'ecological' and systemic framework that reflects the importance of balance and harmony among key and interrelated elements. The interplay between the four dimensions of an individual's being (physical/material, emotional/relational, mental/intellectual, and spiritual/cultural) for achieving well-being is integral in the aboriginal understanding and approach to health. Balance

Working paper

and harmony are key elements inextricably linked to the experience of health and wellness. Living in balance and harmony is equated with health and well-being, while disharmony and imbalance invite illness, increase vulnerability and undermine safety.

Cultural Safety: a different way to measure outcome

Stigma, stereotypes and embedded structural inequality have long been barriers for indigenous people seeking or needing health care service and have created environments of care that historically are experienced by many aboriginal people as unsafe, risky an dangerous. In their encounters with non-aboriginal health care providers and organizations, many aboriginal people have and continue to experience their cultural identity, values and ways of being challenged or disregarded. This is the antithesis of cultural safety.

Different from the linked concepts of cultural awareness, sensitivity and competency which respectively reflect the skill, knowledge and awareness of service providers in appreciating and respecting differences among cultures, the concept of cultural safety reflects the experience of the recipient. Regardless of how culturally aware, sensitive and competent we as service providers think we have been in any given encounter, it is how the recipient experiences the encounter with us in terms of feeling that their cultural identity, values, ways of knowing and being were respected, that determines cultural safety.

While cultural awareness, sensitivity and competence are necessary and contribute to a recipient's experience, the concept of cultural safety challenges non-aboriginal service providers to go further and practice in a different way. In her research on Cultural Safety Jessica Ball has outlined 5 principles that will assist service providers in increasing the likelihood of creating culturally safe environments and encounters. They are:

1. Protocols: being informed and respectful of cultural forms of engagement, seeking cultural knowledge, engaging allies to accompany, mentor and guide.
2. Personal Knowledge: critical reflexivity-being mindful of one's own cultural identity, values, beliefs, assumptions and social-historical location in relation to client.
3. Partnerships: engaging collaboratively with clients in the process of identifying issues and co-constructing solutions and action plans; strengthening mutual capacity by sharing knowledge and insight
4. Process: ensure equity and dignity of all parties involved, negotiate goals and activities, talk less and listen more.

Working Paper

5. Positive Purpose: build on strengths, ensure confidentiality, be accountable, make your actions matter.

Specific Models of Cross Cultural Practice

First Nations Holistic Policy and Planning Model: social determinants of health approach.

This model was developed by the Assembly of First Nations (AFN) and draws on existing work, as well as other national and international models that have identified specific determinants of health, which represent all of the factors affecting health. It is a holistic approach which embeds health in a broader social context. It is unique in that it highlights the significance of self-government to First Nations' well-being. The AFN argues that in order to achieve sustainable solutions in improving the health and wellness of First Nation individuals and communities, First Nations themselves must have a central role in identifying needs as well as directing and implementing change (2007).

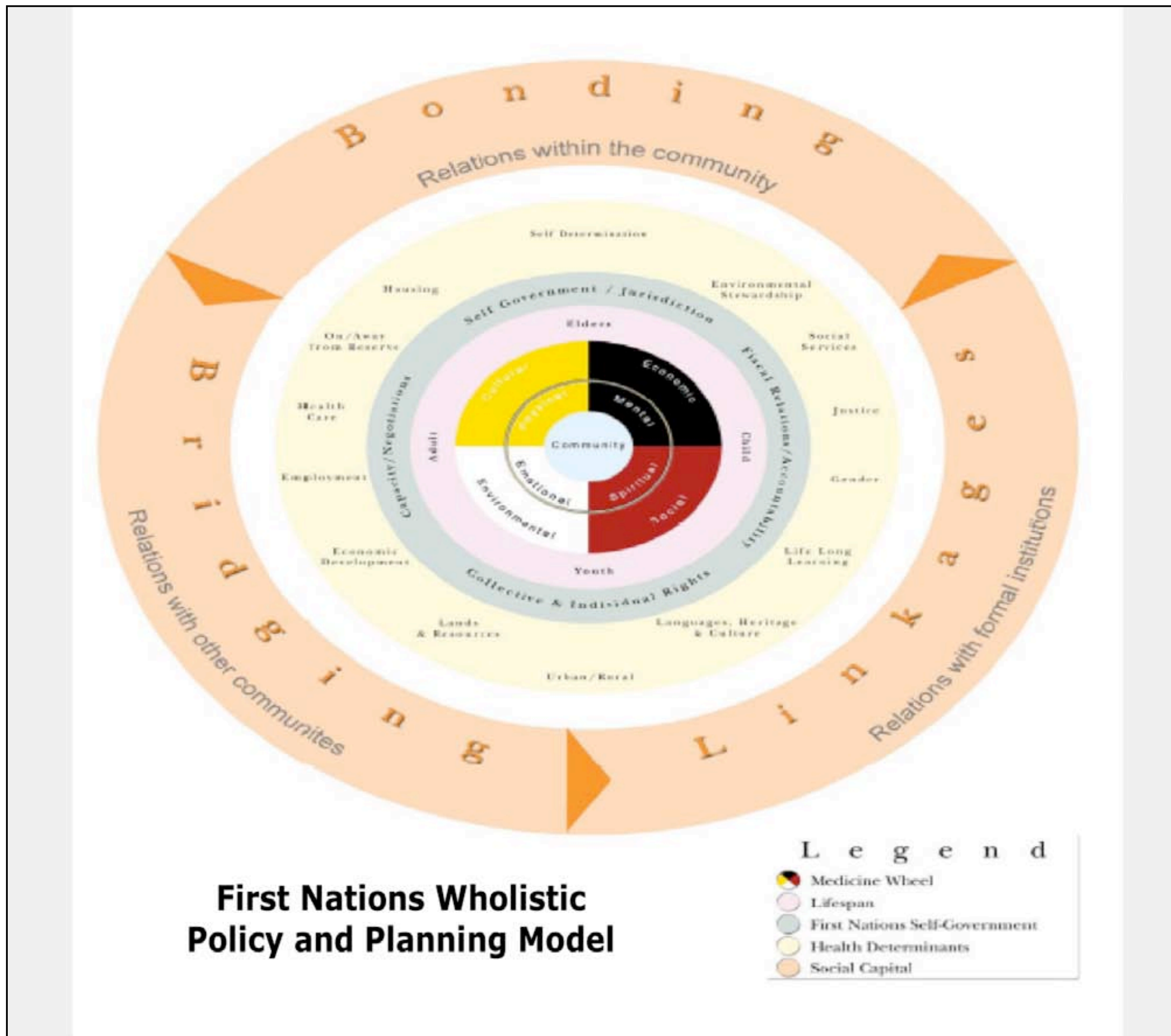
There are several other aspects of this model that make it distinct, particularly when compared against the dominant 'biomedical' model. While mainstream approaches to health examine some determinants of health, such as housing, employment and education, it does not readily acknowledge the negative health impact of colonialism and is culturally limited in its definition of wellness (as quoted in, Reading et al, 2007, p.21). Mainstream models also understand health determinants as being in a cause and effect relationship with health status, while the AFN model sees health status being determined by balance throughout and across the determinants.

In addition, Reading, et al., 2007 suggest that the AFN model is distinct because of several key characteristics. It places 'community' at its core; the health and well-being of the individual is understood in the context of and interconnection with community. The influence of the Medicine Wheel is significant with the four directions articulated at the individual level (spiritual, physical, mental and emotional) as well as the community level (cultural, economic, social and environmental). It also acknowledges the connection between the experience of health and wellness and development across the lifecycle (child, youth, adult and elder). These directions constitute domains through which additional components can be understood, such as the four key dimensions of First Nation self-government (self-government/jurisdiction, fiscal relationships/accountability, collective and individual rights, capacity/negotiations); social determinants of health; and the three components of 'social capital' (bonding – relationships

Working paper

within the community, bridging-relationships with other communities, and linkage- relations with formal institutions).

Reading (2007). *First Nations Wholistic Policy and Planning Model: Discussion*



Paper for the World Health Organization Commission on Social Determinants of Health. Assembly of First Nations, Ottawa, Ont.

First Nations RHS Cultural Framework.

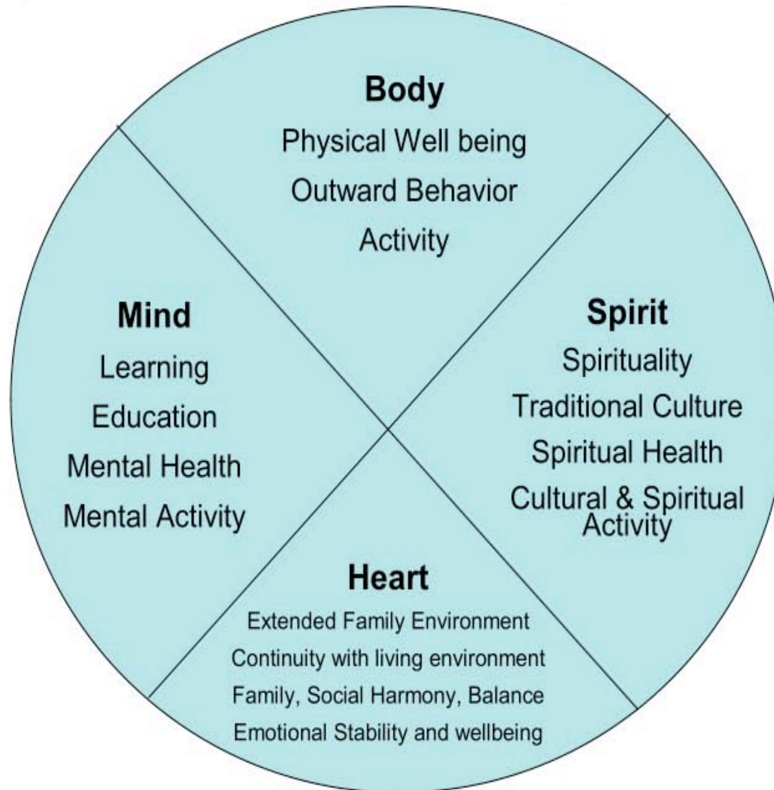
Total Health, Total Person, and Total Environment

Created to guide the analysis and interpretation of the First Nations Regional Longitudinal Health Survey (RHS), a ten-year First Nations-led research initiative looking at the health of adults, children and youth living in First Nations communities across Canada, is a Cultural Framework that considers 'health' in ways that are inclusive of the 'total' person, 'total' health and 'total environment. The concept of 'total Health' recognizes the interconnectivity of all aspects and components of health and well being within an inclusive and interactive web of life and living. The 'total person' is inclusive of all levels of personhood - body, mind, heart and spirit – and includes physical, mental, emotional and spiritual health; healthy behaviour and lifestyle; and, healthy connections to culture, family, community and spirituality. 'Total environment' is understood to mean a healthy connection and relationship with the living environment, including self, family, community and culture.

This 'cultural' definition of health stands in stark contrast to the traditional "western" definition of health, which focuses primarily on the physical and biological functioning of the body and the cognitive functioning of the mind. The goal of western medicine is to 'fix' the functional problems of the body and mind brought about by injury, illness, disease, or generalized decline. Pain and symptoms are managed, function is assessed, treatment is prescribed and outcomes are measured. By solely focusing on the body and mind, the traditional approach to defining health and well-being misses two vital dimensions of the 'total person', without which an accurate assessment of health and well-being is impossible.

The cultural framework provides a useful tool for a more comprehensive, holistic and culturally appropriate assessment of health and well-being. Utilized in the context of adult abuse and neglect it has the potential of informing a broader and more accurate understanding of the client ('total person'), his or her health and well-being ('total health), his or her social and cultural environment ('total environment') and the interconnection between all three.
Later phases of the Orientation will develop questions to accompany the framework.

Working Paper



Reading (2007). *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. Assembly of First Nations, Ottawa, Ont.

Listening for Meaning: an Integrative Model

This research-based practice model, emerged in response to questions of "how" frontline practitioners working in culturally diverse practice settings go about understanding the worldview or frame of reference of those with whom they work (Clark, 2006). Fundamental to this model is an open, holistic, inquisitive stance aimed at exploring and creating a shared understanding of the multiple, intersecting meanings and the source of those meanings, embedded in a client's lived experience.
In Clark's view spirituality is an integral 'dimension; of worldview. Her research based model is designed as one to allow that to emerge in terms of meaning because there is 'space' for that to happen.

This model identifies four integral dimensions of the holistic process of creating shared understanding and meaning: inquiring, interpreting, implementing and improvising. They are not sequential steps or discrete practice elements common to traditional clinical practice, but rather point to a multidimensional, fluid, active, interconnected process of mutual and collaborative exploration.

Inquiring:
Epistemological Humility and Critical Reflexivity are two key themes that are reflected in the model's particular stance towards understanding meaning 'Epistemological Humility**'** recognizes and honours multiple ways of knowing and diverse standpoints from which to view reality (Clark, 2006). The clinician, as 'humble knower' acknowledges the partiality of his or her knowledge and humbly seeks to understand the client's unique perspective, meanings and interpretation of his or her own lived experience. 'Critical Reflexivity' is a process whereby the clinician recognizes that his or her worldview is socially and culturally located, and actively engages in a critical examination of how his or her own location and worldview influences what is seen and not seen, what is understood and not understood (Clark, 2006). Together, epistemological humility and critical reflexivity constitute an approach to inquiry that stands in stark contrast to the 'expert' stance of traditional practice.

Interpreting:
The model identifies three key characteristics of the interpretive processes that guide the practitioner and client in collaboratively understanding the meaning that people ascribe to their lived experience: reciprocal, inductive interpretation of meaning; weaving many ways of knowing; and, locating the personal within the structural. Reciprocal, inductive interpretation of meaning is a process of back and forth dialogue between client and clinician where meaning and interpretations emerge, and are examined, modified and confirmed. Weaving many ways of knowing recognizes that there are multiple and intersecting ways of knowing including personal, experiential, cultural, and indigenous, which influence the way a person makes sense of the world and their place in it.

Working paper

Collaboratively, client and clinician weave together their collective sources of knowledge and experience to enhance meaning, deepen understanding and

broaden the emerging narrative. Locating the personal within the structural emphasizes the importance of situating a client's personal story within a broader societal narrative. This allows the collaborative interpretation of meaning to be more contextualized and holistic, highlighting how personal stories and the construction of identity is shaped by the dominant cultural and societal discourses.

Implementing

This third dimension addresses specific conversational practices that facilitate the exploration of world-views and meaning systems (Clark 2006). They go beyond "how to" techniques and 'ticky-box' tools, and focus on the process of creating space for safe, collaborative dialogue to occur where meaning is examined and shared understanding is negotiated. Three practices were identified as being particularly helpful in this process: inviting the client to educate the practitioner; asking for stories, and; exploring contextual meaning. In '***inviting the client to educate the practitioner'***, the practitioner positions oneself as a learner. This fits with the earlier mentioned concept of 'humble knower', whereby the clinician intentionally moves away from an 'expert' stance by acknowledging the partiality of his or her knowledge, honoring the client's unique meanings and interpretations and engaging the client in a reciprocal and collaborative dialogue. The importance of narrative is acknowledged in the intentional practice of '***asking for stories'***. Stories provide a vehicle for uncovering and understanding the meanings that underscore a person's interpretation of the world and their place in it (Clark, 2006). In the telling and retelling of stories, clients are able to hear and understand their own voice, and in collaboration with others construct new meanings and perceptions of their relationship to themselves, to others and to the world. ***'Exploring contextual meanings'*** is the third conversational practice. Crucial to understanding the 'whole' is the need to explore and understand the context of a person's social, religious and cultural background and how these are linked to how the presenting issue is understood and experienced by the client.

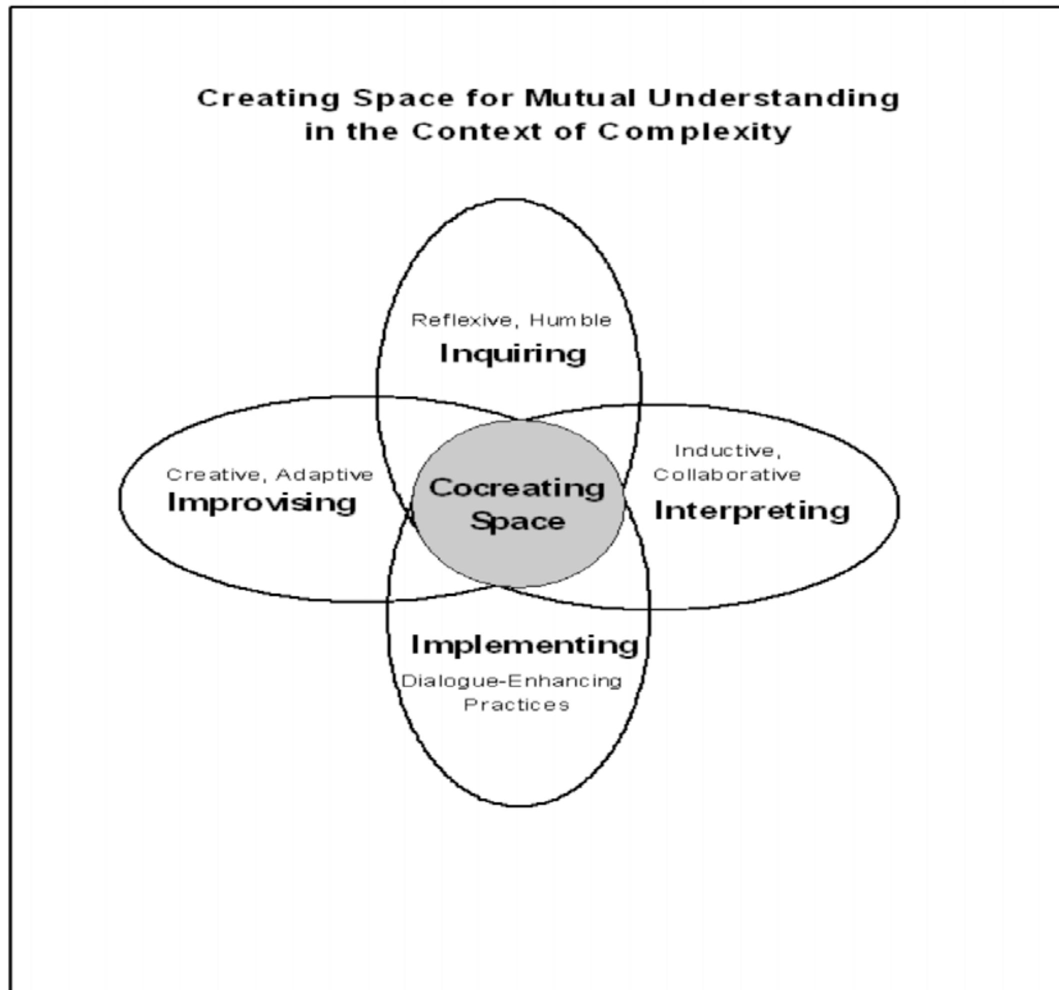
Improvising

The fourth and final theme of the model involves creative, adaptive improvisation, whereby the clinician engages in a continual process of shifting and adapting as circumstances and client's interpretations of themselves and their reality change. Clinicians are seen as 'skillful improvisers who can think on their feet in the face of complexity, reflect an openness to diverse standpoints, and respond creatively in ways that help generate new knowledge and new understanding' (Clarke 2006). An important catalyst for improvisation is the response to misunderstanding and surprise. If approached with openness mistakes, miscues and failures to communicate can become vital sources of new learning as client's

Working Paper

and clinicians alike, learn to negotiate understanding across difference.

A Culturally Safe Way of Being – least intrusive /most effective



Clark, J. (2006). Listening for Meaning :A Research Based Integrative Model for Attending to Spirituality, Culture and Worldview in social work practice. *Critical Social Work, Vol. 7, No. 1.*

Conclusion

Being Least Intrusive: mitigating risk and vulnerability in the area of abuse and neglect

The dominant orientation to clinical practice in healthcare privileges a biomedical understanding of health, which is to say that health is primarily defined by and refers to the physical condition and functioning of an individual's body and mind. While there has been movement towards an understanding of health as more than just the absence of disease and illness, that the mind and body are not separate from each other but interconnected, and that a patient's environmental and social context is directly linked to health outcomes, this kind of balanced and holistic understanding of health continues to be undermined by the 'managed care' approach to healthcare delivery. Health care decisions are primarily made by "experts" who are informed by evidence based 'best practice' guidelines, are supported by standardized tests, and validated by measurable outcomes. Consistent with other 'one size fits all' approaches, there is little room to acknowledge diversity of culture, location, and history, value alternate ways of knowing, and understand how these differences influence and shape an individual's experience of health and well-being.

There is perhaps no other area in front line healthcare practice that exposes the shortcomings of a 'medically' driven approach to care than in the complex work of investigating reports of abuse and neglect of vulnerable older adults. The BC Adult Abuse and Neglect Prevention Collaborative (2009) recognizes that intervening in situations of suspected abuse and neglect is a complex endeavor that extends beyond the limits of medical expertise. It involves an understanding of an individual's social and cultural context, level of risk, and the interplay between the individuals involved, the environmental and social context in which they live, and the physical, mental, emotional, and spiritual functioning of the vulnerable adult as well as the suspected abuser (p.9). Increasing the complexity of this work further, is a clear recognition that a different orientation to practice is needed when working in the area of abuse and neglect with First Nations adults, families and communities.

Of paramount importance in cross-cultural practice with First Nations people is the concept of 'cultural safety'. Mainstream clinicians can be informed by cross-cultural education and practice from an anti-oppressive stance and still inadvertently dismiss, misunderstand or misrepresent the cultural identity, language, beliefs, values and history of colonization of Aboriginal clients or communities (Sinclair, 2004). Non-aboriginal health care clinicians and service providers are not free from colonial influence; they are not neutral agents, either in practice or action. The awareness of this reality contributes to the complexity of front line work in the area of abuse and neglect of older First Nation adults.

Working Paper

The challenge then for frontline clinicians is to engage in critical and reflective practice, holding an awareness of one's own location, history and culture while at the same time honoring the diversity of culture, beliefs and ways of knowing held by the client. This ensures a 'culturally safe' encounter where space is created for a collaborative and respectful process between clinician and client, in which deeper understanding, empowerment, healing and restoration occurs.

Emerging research, training and education in Aboriginal social work suggests that incorporating critiques of colonial history into practice knowledge is absolutely necessary in order to contextualize the contemporary reality of Aboriginal health and well-being (Sinclair, 2004). It is impossible to understand, for instance, the reality of abuse and or neglect of older First Nations adults without acknowledging the historical context of colonization, the experience of intergenerational trauma as a result of sustained systemic oppression, and the deleterious impact of both on the individual and collective health and wellbeing of Aboriginal people. For the frontline clinician, a critical analysis and understanding of history, as experienced by Aboriginal people is crucial to engaging in culturally relevant and safe practice. Also emerging from research is the awareness that utilizing a 'hybrid' approach to practice, which incorporates indigenous knowledge and traditional healing approaches with appropriate and useful mainstream theory and practice models contributes to successful programs and intervention strategies within First Nation communities, as well as when services are being provided across cultures by 'non-aboriginal' healthcare clinicians (Sinclair, 2004).

The orientation to practice offered in this paper is a 'hybrid' approach to the specific work of responding to issues of abuse and neglect of vulnerable older First Nation adults. Critical to this orientation is an acknowledgment that culturally safe practice requires careful, intentional and respectful collaboration between Aboriginal and Non-aboriginal healthcare clinicians, service providers, and involved community members. The value of drawing on the AFN Social Determinants of Health model and the First Nations RHS cultural framework is that it grounds this orientation to practice within a First Nations cultural paradigm. The integration of aboriginal perspectives necessitates the acknowledgment that First Nation people's health and wellness cannot be understood or determined without discussing culture, language, worldview and spirituality. The circumstances of individual's must be explored within a social, historical and cultural context, fundamentally acknowledging the interconnection between the multiple and layered domains comprising the 'total health' of the 'total person' in his/her 'total environment'. This holistic approach provides a depth to practice knowledge; it provides a broader lens through which risk and vulnerability can be more accurately assessed and health and well-being can be better interpreted, understood and supported.

Working Paper

Practice in the area of abuse and neglect of vulnerable older adults is a complex endeavor. Working across cultures creates additional layers of complexity. Responding to and intervening in situations of abuse and neglect of older First Nation adults, 'most effectively and least intrusively', requires a fundamentally different approach. It requires a different dialogue and a different level of engagement. It requires us to enter into unfamiliar spaces. Whether we are invited to do so or not, one of the most challenging aspects of this work, is finding ways to respectfully and humbly enter into these spaces - creating opportunities for full, even conflicting narratives to emerge, taking time to listen and understand multiple perspectives, holding sacred these voices and co-create meaningful and effective responses that mitigate risk and vulnerability and preserve dignity both for the individual and community.

Working paper

Authors:

Lindsay Neufeld, MSW, RSW is a social worker working for Vancouver Island Health Authority in their Home and Community Care Program. She has practiced as a social worker in the field of health care for the past 10 years. Her primary areas of practice include: elder abuse and neglect, palliative care and dementia care. Since 2006 she has been a member of the provincial Reference group for First Nations – a committee of the BC Adult Abuse/Neglect Prevention Collaborative.

April Struthers, MEd, BA, RCC is an organizational consultant who often works across sectors and professions to develop partnership, organizational and community capacity. April has worked with several First Nations as therapist, program developer / evaluator, leadership developer; and has served a 20 year apprenticeship as learner with the Sechelt (Shishalh) Nation. April owns Wit Works Ltd – www.witworks.ca; and works in the UK regularly.

Under contract to the BC Association of Community Response Networks and the Public Guardian and Trustee of BC; April has worked with Health Authority staff, managers, and First Nations community leaders and workers to develop least intrusive and most effective ways of approaching adult abuse/ neglect, at community and individual levels.

Lindsay and April have worked since 2005 at Provincial, regional and local levels to develop dialogues, relationships with First Nations communities, and health and social service staff. They often travel to rural and remote areas by car, ferry, boat and air. This paper is the result of proximity, curiosity, and the 'conversations that matter'. This is one of a number of projects currently being undertaken by Lindsay and April, including one for the Public Health Agency of Canada.

Working Paper

Bibliography

Ball, J. (2008*). Cultural Safety in practice with children, families and communities.* Early Childhood Development Intercultural Partnerships, University of Victoria. Victoria, BC. Retrieved from www.ecdip.org/culturalsafety/

Baskin, C. (2006). Aboriginal World Views as Challenges and Possibilities in Social Work Education. Critical Social Work, 2006, Vol. 7, No. 2. Retrieved from http://web4.uwindsor.ca/units/socialwork/critical.nsf/982f0e5f06b5c9a285256d6e006cff78/536be566187cf89285257277002adb1d!OpenDocument

Bent, K. (2009*). Literature Review: Aboriginal Senior Abuse in Canada*. Native Women's Association of Canada. Ottawa, Ont.

Butot, M. (2005). *Reframing Spirituality, Reconceptualizing Change: Possibilities for Critical Social Work.* Critical Social Work, Vol. 6, No. 2.

Clark, J. (2006). Listening for Meaning: A Research Based Integrative Model for Attending to Spirituality, Culture and Worldview in social work practice. *Critical Social Work, Vol. 7, No. 1.*
http:www.cronus.uwindsor.ca/units/socialwork/critical.nsf/main/

Dell, Colleen, Debra Dell, Carol Hopkins. (2005*). Resiliency and Holistic Inhalant Abuse Treatment.* Journal of Aboriginal Health.
www.naho.ca/enlish/communications_journal.php

Dumont, J. (2005). *Cultural Framework*. National Aboriginal Health Organization.

First Nations Centre. (2009) *Health Information, Research and Planning: AN Information resource for First Nations Health Planners*. National Aboriginal Health Organization. Ottawa, Ont.

Hart, M (1999) Seeking *Mino-pimatasiwin (the good life): An aboriginal approach to social work practice*. Native social work Journal 2(1), 91-112

Ives, Nicole, Oonagh Aitken, Michael Loft and Morgan Phillips. (2007*). Rethinking Social Work Education for Indigenous Students: Creating Space for Multiple Ways of Knowing and Learning.* First People's Child and Family Review. Vol. 3, No 4, 2007, pp. 13-20.

Jefferey, B. and S. Abonyi (2008) .*First Nation's Health Development: Tools for Assessment of Health and Social Service Program Impacts on Community Wellness and Capacity***.** Regina, Sask. Saskatchewan Population Health and Evaluation

Working Paper

Jiwa, Ashifa, Len Kelly, ST Natalie Pierre-Hansen. *(2008). Healing the Community to Health the Individual: Literature Review of aboriginal community-based alcohol and substance abuse programs*. Canadian Family Physician, Vol.54, No 7,July 2008, pp.1000-1000.e7

Kwakiutl District Council (2009). KDC Health Forum: Our Journey Towards Improved Health and Well Being in Our Communities. Retrieved from KDC Health Forum, Campbell River, BC.

Ludwig, Katrina (2007). Patients First Project, Final Report – Interprofessional Working Network of BC (Northern Health, UNBC, Carrier Sekani Family Services, Central Interior Native Health Society). https://www.unbc.ca/docs/final_reports/PF_Project Report-07.pdf

Reading, J. and Elias B. *First Nations and Inuit Regional Health Survey - National Report.* An Examination of Residential Schools and Elders Health National Steering Committee First Nations and Inuit (Labrador) Regional Health Steering Committee.

Reading, Jeffrey L.; Andrew Kmetic, Valerie Gideon. (2007). *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. Assembly of First Nations, Ottawa, Ont. Retrieved from www.afn.ca/cmslib/general/07-05 28_AFN_Paper_to_WHO_Commission_on_Social_Determinants_of_Health.pdf

Sinclair, R (2004) *Aboriginal Social Work Education in Canada: Decolonializing Pedagogy for the seventh generation*. First Peoples Child and Family Review, Vol. 1, No. 1, pp 49-61.

Strategy, Competencies and Standards: Nuu-Chah-Nulth Nursing Program. www.nuuchahnulth.org/tribal-council/nursing.html

Vancouver Island Health Authority. (2006). Aboriginal Health Plan. Victoria, BC: Vancouver Island Health Authority

Verniest, L. (2006). Allying with the Medicine Wheel: Social Work Practice with Aboriginal People. Critical Social Work, 2006 Vol.7, N0. 1 http://cronus.uwindsor.ca/units/socialwork/critical.nsf/main/9979F6E595E176DB852571790073C215?OpenDocument

Waldrem, James B. (2008). *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*. National Network for Aboriginal Mental Health Research/Aboriginal Healing Foundation. Ottawa, Ont. Retrieved from www.afn.ca/pages/downloead/28___13344

Working paper

___________ (2005). A First Nations Holistic Policy and Planning model: Health Determinants Perspective. Assembly of First Nations. Ottawa, Ontario.

_________ (2008). *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators.* National Aboriginal Health Organization, Ottawa, Ont.

_________(2008). Elder Maltreatment: Risk and Protective Factors. Centers for Disease Control and Prevention, Department of Health and Human Services, Atlanta, Georgia.
http://www.cdc/gov/ViolencePrevention/eldermaltreatment/riskprotectivefactors.html.

_________(2004). A Statistical Profile on the Health of First Nations in Canada. Determinants of Health, 1999-2003. Health Canada. Ottawa.
http://www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/index-eng.php

________(1997). *Hearing Our Stories*. Native Women's Association of Canada for Seniors Directorate of Health Canada. Ottawa, Ont.

________ (2008). *Indigenous Women and violence.* Femmes Autochtones Du Quebec Inc. /Quebec Native Women. Presentation to United Nations Special Rapportuer on Violence Against Women, January 2008.

________(2009). Nuu-Chah-Nulth Nursing Service. CASE Competency Course. www.nuuchahnulth.org.

________ (2005). *The Prevention of Elder Abuse Policy and Program Lens.* Prevention of Elder Abuse Working Group. Ontario Secretariat /Elder Health Coalition. Toronto, Ont.
www.culture.gov.on.ca/seniors/english/programs/elderabuse/docs/ElderAbuse_Eng_web.pdf

________(2004). Preliminary Findings of the First Nations Regional Longitudinal Health Survey (RHS) 2002 – 2003: Adult Survey. Assembly of First Nations. Ottawa.
http://www.afn.ca/article,asp?Id=103

________(2009). Provincial Strategy Document: Vulnerability and Capability Issues in British Columbia. BC Adult Abuse / Neglect Prevention Collaborative. Vancouver, BC.

________(1998). Reaching Out: Communicating with Aboriginal Seniors. Health Canada, Ottawa, Ont.

Working paper

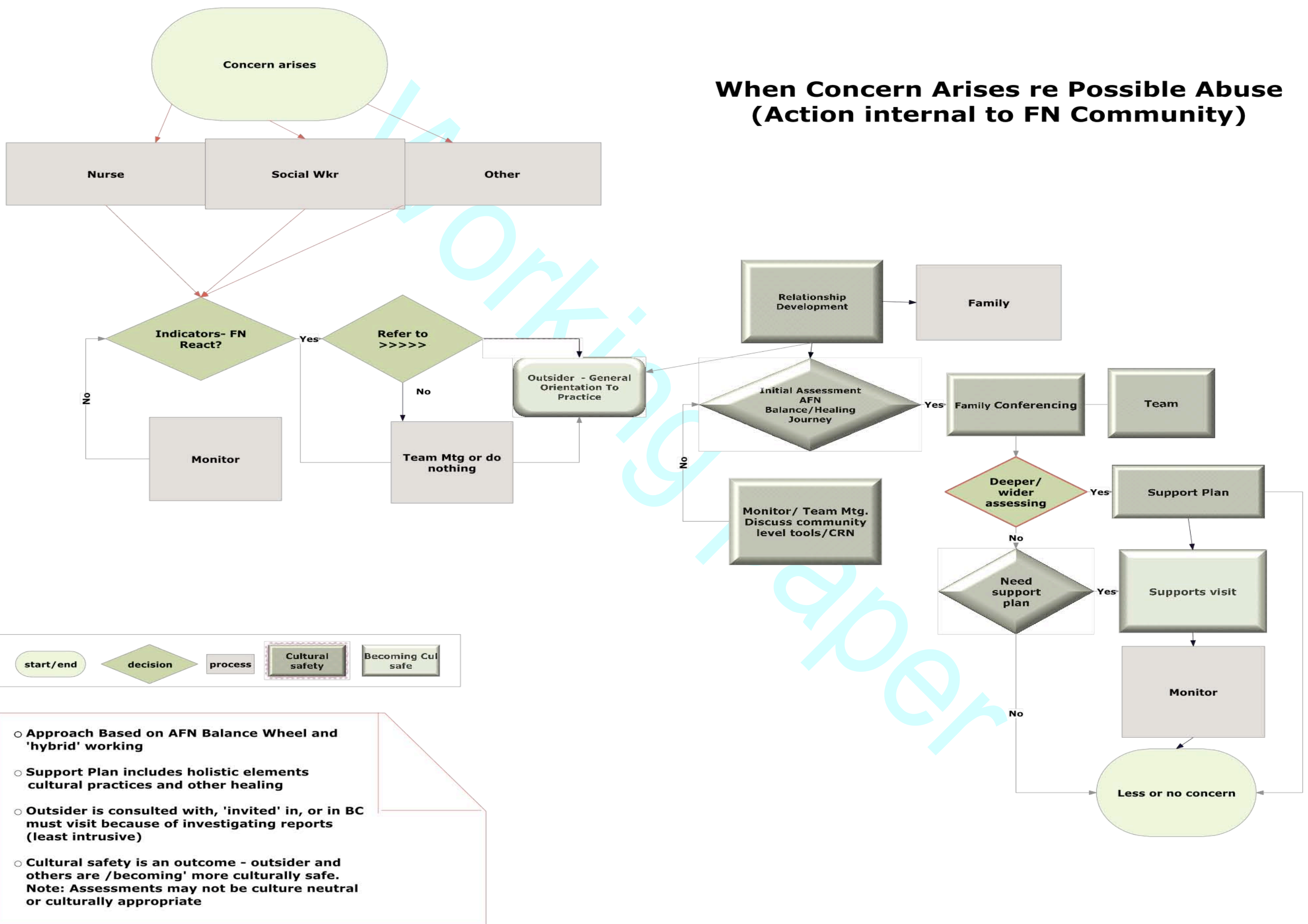
Appendix 1:

Flowchart of process: being least intrusive in response and intervention

The following flowchart illustrates a process of response and intervention in line with the principles embedded in "Being Least Intrusive: an orientation to practice in response to situations of abuse, neglect and self-neglect of vulnerable First Nation adults". It is meant to be utilized within First Nation communities as a tool, complimentary to other resources, to assist in building capacity for front line service providers as well as engaged community members in effectively and appropriately responding to concerns of abuse, neglect and self-neglect of vulnerable First Nation adults. It can be utilized in a variety of ways, but has the intent on graphically illustrating the decision making process from the point of when a concern about vulnerability, abuse and neglect arises through various levels of support, assistance and intervention.

The first half of the flowchart represents the part of the process that can be followed within the community, integrating established protocols and specific to the community's traditional values and ways of being, strengths and capacity, resources and services. The second half of the flowchart represents the part of the process where First Nation communities decide that it is appropriate and or necessary to access external service providers to assist with providing support and assistance, or in the case of British Columbia, making formal reports of abuse and neglect to a designated agency. It is here where the principles guiding the 'being least intrusive orientation to practice, become most important and this flowchart becomes a helpful tool in assisting external, mainly non-aboriginal service providers, to engage thoughtfully, respectfully and in a culturally safe manner with the First Nation individuals and communities they partner with.

Working Paper



Working Paper